COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

TITLE IV-E FOSTER CARE & MEDICAID* APPLICATION/REDETERMINATION

*(Separate Medicaid application required for noncustodial agreement cases)

CASE NUMBER_____ CLIENT ID_____
COUNTY/CITY_____
WORKER_____
☐ APPLICATION ☐ REDETERMINATION ☐ ADOPTION ASSISTANCE SCREENING

I. IDENTIFYING INFORMATION

CHILD'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SEX	RACE	SSN ☐ OR DATE APPLIED FOR SSN ☐

MOTHER'S NAME ADDRESS SSN	FATHER'S NAME ADDRESS SSN

IF THE CHILD WAS RECEIVING OTHER ASSISTANCE WHEN BROUGHT INTO FOSTER CARE, GIVE THE CASE NAME AND/OR CASE NUMBER

II. COMMITMENT INFORMATION

COURT ORDER		VOLUNTARY PLACEMENT AGREEMENT (VPA)	
☐ INITIAL COURT ORDER DATED OR ☐ ANNUAL JUDICIAL REVIEW DATED _____ COPY ATTACHED? ☐ YES ☐ NO	REQUIRED JUDICIAL LANGUAGE REASONABLE EFFORTS? ☐ YES ☐ NO CONTRARY TO THE WELFARE ? ☐ YES ☐ NO REQUIREMENT MET? ☐ YES ☐ NO	CHECK VPA TYPE ☐ TEMPORARY ENTRUSTMENT ☐ PERMANENT ENTRUSTMENT ☐ NONCUSTODIAL AGREEMENT	VPA DATED _____ COPY ATTACHED? ☐ YES ☐ NO

III. PLACEMENT INFORMATION

TYPE PLACEMENT ☐ FOSTER HOME ☐ FOR PROFIT CPA FOSTER HOME ☐ NONPROFIT CPA FOSTER HOME
☐ PUBLIC INSTITUTION SERVING 25 OR LESS ☐ PRIVATE RESIDENTIAL FACILITY ☐ OTHER _____
PLACEMENT NAME & ADDRESS _____
_____
IF THE CHILD IS A QUALIFIED ALIEN, IS PLACEMENT WITH AN UNQUALIFIED ALIEN FOSTER PARENT? ☐ YES ☐ NO

DATE OF PLACEMENT

APPROVED FROM/TO

VERIFICATION ATTACHED?
☐ YES ☐ NO

MONTHLY MAINTENANCE COSTS (Food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance on child, and reasonable travel for child's visitation with family or other caretakers)

FC CHILD CHILD OF FC CHILD

IV. NON-FINANCIAL INFORMATION ☐ APPLICATION ☐ REDETERMINATION (Omit #1 - 5)

1. ELIGIBILITY MONTH:_____
(month court action was initiated/petition filed or entrustment/noncustodial agreement was signed)

2. LAST PLACE OF RESIDENCE_____
(city & state)

3. SPECIFIED RELATIVE/REMOVAL HOME DATE REMOVED _____ IF NOT REMOVED, ENTER REASON _____

NAME OF PARENT/RELATIVE WITH WHOM THE CHILD LAST LIVED _____. WAS THE CHILD REMOVED FROM THIS PARENT/RELATIVE?

☐ YES COMPLETE #5 BELOW FOR THE ELIGIBILITY MONTH (this is the removal home)
☐ NO COMPLETE #4 AND #5. (the removal home is the home where the child last resided within six months of the eligibility month)

4. LIST ALL LIVING ARRANGEMENTS FOR THE SIX MONTH PERIOD PRIOR TO THE ELIGIBILITY MONTH

FROM/TO	NAME & ADDRESS	RELATIONSHIP

5. LIST PARENT/RELATIVE, MINOR SIBLINGS, STEPPARENT, AND CHILD OF THE FOSTER CARE CHILD RESIDING IN THE REMOVAL HOME.

NAME & ADDRESS_____
MINOR SIBLINGS OF CHILD (Include age and deprivation reason for each child)_____
_____
STEPPARENT_____ CHILD OF FC CHILD_____ NUMBER IN FAMILY UNIT_____

6. DEPRIVATION - WAS THE CHILD DEPRIVED OR DOES THE CHILD CONTINUE TO BE DEPRIVED OF PARENTAL SUPPORT AND CARE OF ONE OR BOTH PARENTS DUE TO:

A. CONTINUED ABSENCE FROM HOME OF A PARENT ☐ YES ☐ NO WHICH PARENT(S):_____
B. PATERNITY NOT ESTABLISHED ☐ YES ☐ NO NAME, IF KNOWN:_____
C. DEATH OF A PARENT ☐ YES ☐ NO WHICH PARENT(S):_____
D. INCAPACITATED PARENT (BOTH PARENTS IN THE HOME) ☐ YES ☐ NO WHICH PARENT(S):_____
E, UNEMPLOYED PARENT (BOTH PARENTS IN THE HOME) ☐ YES ☐ NO WHICH PARENT(S):_____
F. PARENTAL RIGHTS TERMINATED MOTHER ☐ YES ☐ NO FATHER ☐ YES ☐ NO (n/a for applications)

7. CITIZENSHIP/ALIENAGE DECLARATION (REQUIRED BY LAW UNDER PENALTY OF PERJURY) CHILD IS: U.S. CITIZEN ☐ ALIEN ☐
ALIEN NUMBER _____ ENTRY DATE_____ (Attach INS document) ☐ UNDOCUMENTED ALIEN

8. ENROLLED IN SCHOOL? ☐ YES ☐ NO NAME OF SCHOOL_____ GRADE_____
IF CHILD IS 18, IS HE/SHE EXPECTED TO COMPLETE THE COURSE OF STUDY BY AGE 19? ☐ YES ☐ NO

9. CHILD SUPPORT REFERRAL (Application only) - COPY ATTACHED FOR EACH ABSENT PARENT? ☐ YES ☐ NO
IF GOOD CAUSE IS CLAIMED, EXPLAIN_____

V. TITLE IV-E SCREENING - RESOURCES (Indicate amount/value, as appropriate, and date/method verified.)

PROPERTY OWNED BY (Initial eligibility - AFDC assistance unit Ongoing case - FC child only)	FC CHILD		MOTHER	FATHER	SIBLINGS
	Eligibility Month	Situation Changed? If Yes, Explain	Eligibility Month	Eligibility Month	Eligibility Month
CASH					
CHECKING ACCOUNT (name of bank, account #, current balance)					
SAVINGS ACCOUNT (name of bank, account #, current balance)					
SPECIAL WELFARE FUND (current balance)					
IRA/CD (name of bank, account #, current amount available)					
STOCKS/BONDS (current amount available))					
TRUST FUND (current amount available)					
BURIAL FUND (current value)					
LIFE INSURANCE (name of company, policy #, cash value)					
VEHICLE (year, make, model, equity value)					
OTHER (specify type of resource and date/method of verification)					

VI. TITLE IV-E SCREENING - INCOME (Indicate amount and how often received, if applicable, and date/method verified.)

INCOME RECEIVED BY (Initial eligibility - AFDC assistance unit Ongoing case - FC child only)	FC CHILD		MOTHER	FATHER	SIBLINGS
	Eligibility Month	Situation Changed? If Yes, Explain	Eligibility Month	Eligibility Month	Eligibility Month
EARNED					
SSA					
SSI					
VETERANS BENEFITS					
SUPPORT					
RETIREMENT/PENSIONS					
MILITARY ALLOTMENT					
UNEMPLOYMENT COMPENSATION					
WORKER'S COMPENSATION					
OTHER (specify)					

VII. MEDICAL INFORMATION AND ASSIGNMENT OF RIGHTS

DOES THE CHILD HAVE MEDICAL INSURANCE? ☐ YES ☐ NO IF YES, PROVIDE THE FOLLOWING INFORMATION:		1. NAME AND ADDRESS OF COMPANY	
2. POLICY HOLDER	3. POLICY #	4. TYPE COVERAGE	5. EFFECTIVE DATE

DOES THE CHILD HAVE UNPAID MEDICAL BILLS INCURRED DURING THE THREE MONTHS PRIOR TO APPLICATION? ☐ YES NO ☐ UNKNOWN
IF YES, ATTACH SHEET SHOWING INCOME AND RESOURCES DURING THE THREE MONTHS PRIOR TO APPLICATION.

IF YES, GIVE THE DATE EACH EXPENSE WAS INCURRED. _____

ADDRESS TO WHICH THE MEDICAID CARD SHOULD BE SENT

_____

(Name) (Address) (City, State, &Zipcode)

IN ORDER TO RECEIVE MEDICAID, EACH FOSTER CHILD MUST HAVE HIS/HER RIGHTS TO MEDICAL SUPPORT ASSIGNED TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS). THIS MEANS THAT DMAS MUST BE REIMBURSED FOR PAYMENT OF ANY MEDICAL SERVICES RECEIVED FROM ANOTHER INSURER.

☐ I AGREE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD FOR WHOM I HAVE THE LEGAL RIGHT TO DO SO.

☐ I REFUSE TO ASSIGN THE RIGHTS OF THE ABOVE NAMED FOSTER CHILD.

MY SIGNATURE BELOW AUTHORIZES MEDICAID, FAMIS, AND DMAS CONTRACTORS TO EXCHANGE INFORMATION RELATING TO THIS CHILD'S COVERAGE WITH LOCAL EDUCATIONAL AGENCIES. I UNDERSTAND THAT THIS EXCHANGE OF INFORMATION IS NECESSARY TO ASSIST WITH THE APPLICATION, ADMINISTRATION, AND BILLING FOR SERVICES PROVIDED IN SCHOOLS AND THAT I CAN REVOKE THIS CONSENT TO DISCLOSE INFORMATION AT ANY TIME.

_____ _____

(Signature of Service Worker) (Date)

TITLE IV-E FOSTER CARE & MEDICAID APPLICATION/REDETERMINATION FORM

FORM NUMBER – 032-03-636/1

PURPOSE OF FORM – The form serves as a referral for Title IV-E foster care and adoption assistance screening and an application for Medicaid with one exception. When a child enters care through a noncustodial agreement, a separate Medicaid application must be completed and signed by the parent or guardian.

USE OF FORM – This form is to be completed by the service worker and sent to the eligibility worker for use in evaluating Title IV-E and Medicaid eligibility.

NUMBER OF COPIES – IV-E Foster Care and Medicaid - Complete one copy of the IV-E foster care/Medicaid application when an initial referral/application is made and for each subsequent redetermination of eligibility.

Adoption Assistance - Complete two forms: one to provide information necessary to determine initial IV-E foster care eligibility requirements and one to provide information needed to determine eligibility in the month the adoption petition was filed.

DISPOSITION OF FORM – The form is to be filed in the eligibility case record.